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Sp... ...imensions of ... Care

G... ...gical Nu... ...heory

Tr... ...ural Nursing and Nursing Diagnoses

Transformational Leadership

A Sense of Nursing History

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NURSING & HEALTH CARE

April 1991
Volume 12 Number 4

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Transcultural Nursing AND Nursing Diagnoses

Elaine M. Geissler

During the course of a study to validate the use of selected nursing diagnoses with culturally diverse patients, many respondents wrote *unsolicited* comments on their questionnaires or in attached letters. The respondents were all members of the International Transcultural Nursing Society and/or the American Nurses' Association Council on Cultural Diversity in Nursing Practice. Two hundred and forty-five responses were received from 43 states and the District of Columbia, and 16 responses were received from 7 foreign countries: Canada, the Philippines, Sweden, Pakistan, Saudi Arabia, Israel, and Malawi. The desire of these registered nurses (RNs) to improve the status quo, as well as their frustration with the inadequacy of nursing diagnoses in their transcultural nursing practices, became evident. These opinions about the cultural limitations of the North American Nursing Diagnosis Association (NANDA) diagnoses are reported here.

In recent decades, nursing's movement to a more holistic perspective reflects an increased diversity of nursing practice and improved identification of patients' needs. Transcultural nursing recognizes that regardless of the medical diagnosis, it is important to plan nursing care around the unique cultural health care beliefs, values, and practices of patients.

The first organized attempt to develop a classification system for nursing concerns by NANDA was begun in 1973. To date, there has been minimal impact by the evolving transcultural nursing knowledge and practice base upon the content of nursing diagnoses. At best, the list of officially accepted nursing diagnoses (NANDA, 1989) contains only a few cultural defining characteristics and cultural factors that appear to be antecedent to or related to a given nursing diagnosis. Nurses expert in transcultural nursing need to help close this gap and lead the way for integration of culture care into nursing practice.

General comments

General comments about the use of nursing diagnoses to meet the needs of culturally diverse patients were split between those nurses who felt that the NANDA diagnostic classification data base is not adequate and found it impossible to complete the questionnaire, and those who desired to seek accommodation with the system. For example, comments included "I have decided after trying to think about and fill out the questionnaire that I cannot participate," and "Many TCN [transcultural nursing] individuals are so frustrated with NANDA's list that they want to 'throw out the baby' too. More explanation needs to be given on how to adapt the other NANDA diagnoses to be culturally congruent." A few nurses believed that the negatively worded language of nursing diagnoses did not reflect a positive transcultural nursing view. NANDA's most common problems were reported as:

1. Patient, rather than provider or system focused: NANDA diagnoses and behaviors assume the client is "wrong" and the provider is "right" denying the validity of cultural and health care beliefs and practices different from those of the nurse. Patient-focused diagnoses alone are inadequate because it is the nurse from the dominant culture within the health care agency who may be impaired and ineffective.
2. Generalizing: The NANDA system is difficult to generalize among cultures, and there is danger of stereotyping and victimizing. So-called deviations from the dominant culture are automatically and ethnocentrically considered abnormal, thus, interventions from nurses are needed. In reality, other traditional health/illness practices may be far different from the Western health care system model and normal in the patient's culture.
3. Mislabeling: Cultural dissonance as the base etiology of the patient's problem needs to be separated from political, social, psychological, and economic factors.

Respondents also expressed concern over the ability of the study to improve congruence between NANDA's listings and patients' culturally diverse needs. For example, "This is still an attempt by marginally linguistic phraseology to use psychological, social, and some physical terms related to culture. The cultural care is missing. We surely don't want this or we fail to meet TCN purposes." Another nurse wrote, "Trying to do this is a futile and offensive exercise." The respondent did not explain if she was responding to the questionnaire, nursing diagnoses, something else, or everything in general.

General comments were categorized into the following problem areas: (1) inadequacy of NANDA, (2) inadequacy of study, (3) patient-focused nursing diagnoses, (4) generalizing, and (5) mislabeling (Table 1). Four of the five problems were of equal concern (21.7%), with mislabeling of nursing diagnoses (13%) ranked second. All the unsolicited comments were handwritten by respondents and seemed to have emotional messages embedded within them. The way the responses were written, as well as the choice of

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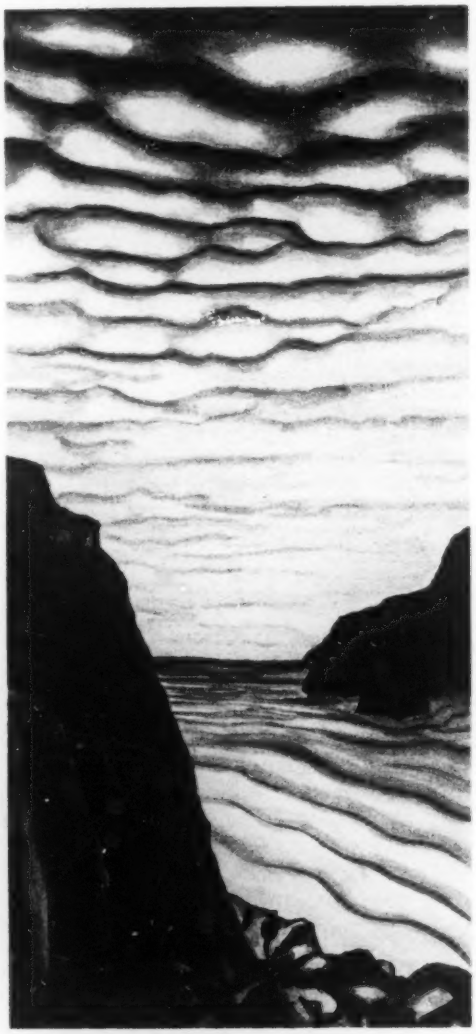
words, were analyzed.

The degree of discontent with the identified problems was extracted from the comments by creating three potential levels of discontent. This approach is suggested by Seymour (1990) with adaptations. Three points were assigned to words or phrases indicating relatively strong negative feelings. For example, "It disturbs one to see it [transcultural nursing in nursing diagnoses] incorporated so negatively." No expletives were found but would have been included in this level. Two points were assigned to exclamation points, highlighting certain words by underlining, and the use of cap letters. For example, "The major problem I have with most of this is that the diagnosis indicates a patient problem—when we the nurses may be the impaired or ineffective." One point was assigned to comments that expressed discontent but without any emphasis devices. For example, "These diagnoses do not consider lots of variables and could lead to labeling and stereotyping." The number of actual points divided by the total possible points resulted in the percent of discontent reported in Table 1.

The simple listing of the problems by frequency and percent revealed some information. But when the level of discontent is added, the data are much more informative. Discontent with the study itself and with the NANDA classification system ranked among the highest (53.3% and 50%, respectively), assuming that the patient is "wrong" and the provider is "right" (30%), and mislabeling nursing diagnoses as having a cultural etiology (27.8%) were of moderate concern. The danger of generalizing or stereotyping ranked the lowest (16.7%).

Verbal communication diagnosis

The first NANDA nursing diagnosis looked at was impaired verbal communication related to cultural differences. NANDA defines this diagnosis as "The state in which an individual experiences a decreased or absent ability to use or understand language in human interaction" (NANDA, 1989, p. 49). When this diagnosis is related to cultural differences, the respondents had considerable difficulty with the diagnosis, the way the related factors are stated, and the defining characteristics indicating presence of the diagnosis. Certainly, inability to use the dominant language of the health care system providers and/or cultural differences in verbal and nonverbal expressions between the patient and the provider must be taken into account. Neither the nurse nor the patient has impaired verbal communication skills when both are adequately fluent in their own languages. The problem is one of barriers to mutual understanding, not the ability to communicate verbally. The nurse



Geissler looks at the fit of nursing diagnosis and transcultural nursing, and she finds nursing diagnosis—at least the most popular taxonomies—wanting. Are our formulations or nursing diagnosis culture-bound?

Key words: transcultural nursing, nursing diagnosis, NANDA, labeling, communication

bears equal responsibility for being *impaired*, if that term is applied.

Defining characteristics addressing pathophysiological causes of the inability to speak, for example, aphasia and stuttering, are irrelevant within the context of cultural-language variance. One nurse suggested adding "...not secondary to physical or psychological disorders" to the end of NANDA's definition. The NANDA classification appears to be used with the assumption that the dominant language is English when it would be more explicit and internationally serviceable to state the defining characteristic as being unable to speak the dominant language of the health care system.

Cultural expression includes nonverbal communication and is different from understanding verbal language. NANDA's descriptors are exclusively directed toward verbal communication and inappropriately relate them to cultural differences, yet the nonverbal expressions of every culture are critical to mutual understanding and may have nothing to do with knowledge of the dominant language.

"Some groups do not value verbalization as much as the dominant culture, however, this isn't a diagnosis; its a norm for that group," one nurse reminds us. With culturally diverse English-speaking clients, mutual understanding may be assumed, but false. For example, when the word *house* is used by a patient, the mental image visualized by the nurse is most likely a middle-class bias of what a house looks like, regardless of whether the two are communicating in English or in the patient's own language.

Culturally based stress and conflict may have no relationship to knowledge of the dominant language, or it may be related to the very real stress of attempting to express oneself in the "foreign" language. Differentiation between these two etiologies is essential for accurate diagnosis and intervention.

. . . It is important to plan nursing care around the unique cultural health care beliefs, values, and practices of patients.

Table 1
Frequency of Problems and Expressions of Discontent

Problem	*f*	%	Discontent (%)
Inadequacy of NANDA	5	21.7	50.0
Inadequacy of study	5	21.7	53.3
Patient focused	5	21.7	30.0
Generalizing	5	21.7	16.7
Mislabeling	3	13.0	27.8
TOTAL		99.9%	

Social interaction diagnosis

The second NANDA nursing diagnosis considered was impaired social interaction related to sociocultural dissonance. The most frequently repeated theme of comments concerned who sets the parameters for what is and is not sociocultural dissonance and who determines dysfunctional behaviors. A more appropriate nursing diagnosis offered was "decreased social interaction." Interaction difficulties must be specified as with the dominant culture, the patient's own culture, or both. One respondent reminds us, "Dysfunction is relative and culturally defined," while another states, "It disturbs me that no attempt is made...to distinguish behavior within our cultural group from behavior in providers' culture."[5] Dissonance only makes sense within a cultural context of health care beliefs, values, and practices.

NANDA defines impaired social interaction as "The state in which an individual participates in an insufficient or excessive quantity or ineffective quality of social exchange" (1989, p. 50). What is excessive quantity is questioned as is the lack of any defining characteristic to identify it. The reason for the patient's involuntary dislocation or voluntary relocation from their original cultural group must be identified to differentiate between political refugees and immigrants or migrants with or without immediate access to family and cultural support systems. Interviewing a patient may seem innocuous to the nurse but may be perceived as a threatening interrogation by a political refugee who is unaccustomed to the exchange of large amounts of personal information in our health care system.

Respondents also viewed the related factor of sociocultural dissonance as vague; a psychological, not a cultural, assessment; and more suggestive of cognitive dissonance. The etiological basis for, accurate definition of, and identification of signs of cultural dissonance are imprecise and difficult to apply in this nursing diagnosis when one is treating patients with cultural variance.

Noncompliance diagnosis

The third and final NANDA nursing diagnosis explored was noncompliance related to patient value system: health beliefs and cultural influences. This nursing diagnosis generated the largest and most emotional number of unsolicited comments and an attached letter. Considerable debate occurred over the phrase *informed decision* in the following NANDA definition for noncompliance: "A person's informed decision not to adhere to a therapeutic recommendation" (1989, p. 67). The consensus was that when a patient decides not to comply for religious, cultural, or other reasons, ethically the nurse should not attempt to alter the behavior. Because the patient often does not share the nurse's view of the cause of health problems, judgment about noncompliance becomes a manifestation of the nurse's own culture and ethnocentric view of health care, and a value conflict ensues. The provider assumes her or his opinion is superior. No matter which value system is followed, the patient's or the provider's, an *informed* decision becomes the patient's *right* to choose.

"According to most published definitions of noncompliance, it is required that the client express desire to comply but inability to stick to

CONTINUED

recommendations," writes one respondent arguing why no diagnosis should be made at all. Another nurse simply wrote, "I hate this!" Others disagree with the diagnosis when it is used in transcultural care settings.

The potential relationship between noncompliance and a person's concept of time was mentioned twice. It has been documented that different cultures view time with varying degrees of importance. "This diagnosis represents imposition of an unacceptable and/or unfamiliar set of expectations on the patient and then proceeds to blame the victim for failure to comply," explains one nurse who will not use this diagnosis in her practice while it remains worded as it is. "Frankly, it embarrasses me!" she writes.

A more culturally relevant diagnosis would employ the word *nonadherence* rather than noncompliance. Nonadherence is a less value laden term that might result in a different set of defining characteristics for this diagnosis. Other nurses believe that noncompliance is often related to a failure in communication or to the patient's belief that treatment would harm him, or it is the provider's assumption that negative consequences would occur from failing to follow the dominant medical/health regimen. One interesting comment suggested that noncompliance is very common in *all* groups regardless of social class or culture and may be related to a personality trait such as compulsiveness, which occurs on an individual level. The comments offered the strong opinion that noncompliance is ethnocentric—a slanted view of the situation reflecting a lack of understanding of the nature of noncompliance related to patients' beliefs, values, and health care practices.

Conclusion

Registered nurses expert in transcultural nursing knowledge and practice have offered their unsolicited opinions that these three nursing diagnoses officially sanctioned by NANDA for use in nursing practice are not adequate to meet the needs of culturally diverse patients. NANDA's most common problems were categorized as (1) assuming the patient is "wrong" and the provider is "right," (2) generalizing or stereotyping behaviors, and (3) mislabeling the etiological basis of a patient's problem as cultural without recognizing other potentially more relevant variables. There was sincere concern expressed that the study would not help ameliorate the status quo.

Neither the nurse nor the patient has impaired verbal communication skills when both are adequately fluent in their own languages.

Responses about the NANDA classification system's use in cultural diversity suggested a dichotomy between not using the system at all and accommodating the system for use in culture care. The reason more commonly given for not using the classification system was because it does not demonstrate respect of patients' individual health care beliefs, values, and practices. Another part of this study looks into the specific changes needed to make the defining characteristics for each of these nursing diagnoses more congruent with transcultural nursing.

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